period for processing the initial permit applications.

If Iowa fails to submit a complete corrective program for full approval by April 1, 1997, EPA will start an 18-month clock for mandatory sanctions. If Iowa then fails to submit a corrective program that EPA finds complete before the expiration of that 18-month period, EPA will be required to apply one of the sanctions in section 179(b) of the Act, which will remain in effect until EPA determines that Iowa has corrected the deficiency by submitting a complete corrective program.

Moreover, if the Administrator finds a lack of good faith on the part of Iowa, both sanctions under section 179(b) will apply after the expiration of the 18-month period until the Administrator determines that the state has come into compliance. In any case, if, six months after application of the first sanction, Iowa still has not submitted a corrective program that EPA has found complete, a second sanction will be required.

In addition, discretionary sanctions may be applied where warranted any time after the expiration of an interim approval period if Iowa has not submitted a timely complete corrective program or EPA has disapproved its submitted corrective program.

If EPA has not granted full approval to the Iowa program by the expiration of this interim approval and that expiration occurs after November 15, 1995, EPA must promulgate, administer, and enforce a Federal permits program upon interim approval expiration.

III. Administrative Requirements

A. Docket

Copies of the state's submittal and other information relied upon for the final interim approval are contained in a docket maintained at the EPA Regional Office. The docket is an organized and complete file of all the information submitted to, or otherwise considered by, EPA in the development of this final interim approval. The docket is available for public inspection at the location listed under the **ADDRESSES** section of this document.

B. Executive Order 12866

The Office of Management and Budget has exempted this action from Executive Order 12866 review.

C. Regulatory Flexibility Act

The EPA's actions under section 502 of the Act do not create any new requirements, but simply address operating permits programs submitted to satisfy the requirements of 40 CFR part 70. Because this action does not impose any new requirements, it does not have a significant impact on a substantial number of small entities.

D. Unfunded Mandates

Under sections 202, 203, and 205 of the Unfunded Mandates Reform Act of 1995 (''Unfunded Mandates Act''), signed into law on March 22, 1995, EPA must undertake various actions in association with proposed or final rules that include a Federal mandate that may result in estimated costs of $100 million or more to the private sector, or to state, local, or tribal governments in the aggregate.

Through submission of these operating permit programs, the state of Iowa has elected to adopt the program provided for under Title V of the Clean Air Act. These rules bind the state to perform certain actions and also require the private sector to perform certain duties. To the extent that the rules being finalized for approval by this action will impose new requirements, sources are already subject to these regulations under state law. EPA has determined that this interim final action does not include a mandate that may result in estimated costs of $100 million or more to state, local, or tribal governments in the aggregate or to the private sector.

List of Subjects in 40 CFR Part 70

Environmental protection, Administrative practice and procedure, Air pollution control, Intergovernmental relations, Operating permits, Reporting and recordkeeping requirements.

Dated: August 16, 1995.

Dennis Grams,

Regional Administrator.

Part 70, title 40 of the Code of Federal Regulations is amended as follows:

PART 70—[AMENDED]

1. The authority citation for part 70 continues to read as follows:

Authority: 42 U.S.C. 7401, *et seq.*

2. Appendix A to part 70 is amended by adding the entry for Iowa in alphabetical order to read as follows:

Appendix A to Part 70—Approval Status of State and Local Operating Permits Programs

* * * * *

Iowa

(a) The Iowa Department of Natural Resources submitted on November 15, 1993, and supplemented by correspondence dated March 15, 1994; August 8, 1994; October 5, 1994; December 6, 1994; December 15, 1994; February 6, 1995; March 1, 1995; March 23, 1995; and May 26, 1995. Interim approval effective on October 2, 1995; interim approval expires October 1, 1997.

(b) [Reserved]

* * * * *

[FR Doc. 95–21760 Filed 8–31–95; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[OMC–011–FC]

Medicare Program; Contracts With Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: This rule clarifies and updates portions of the HCFA regulations that pertain to the following:

- The conditions that an HMO or CMP must meet to qualify for a Medicare contract (Subpart J).
- The contract requirements (Subpart L).
- The rules for enrollment, entitlement, and disenrollment of Medicare beneficiaries in a contracting HMO or CMP (Subpart K).
- How a Medicare contract is affected when there is change of ownership or leasing of facilities of a contracting HMO or CMP (Subpart M).

These are technical and editorial changes that do not affect the substance of the regulations. They are intended to make it easier to find particular provisions, to provide overviews of the different program aspects, and to better ensure uniform understanding of the rules.

DATES: *Effective Date:* These rules are effective as of October 1, 1995.

Comment Date: We will consider comments received by October 31, 1995.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: OMC–011–FC, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201–0001, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850

Because of staffing and resource limitations, we cannot accept comments

by facsimile (FAX) transmission. In commenting, please refer to file code OMC–011–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of the document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890)).

FOR FURTHER INFORMATION CONTACT: Tracy Jensen, (410) 786–1033.

SUPPLEMENTARY INFORMATION:

I. Background

This rule is the fourth in a series of technical amendments that aim to—

1. Make it easier to find particular provisions, for example, by providing paragraph headings to serve as sign posts, using more sections (their headings will appear in the table of contents), and by listing and designating separate provisions that have been ''lost'' in 90-word sentences.

2. Clarify, simplify, and update, for example—

a. By using—

- Shorter words, sentences, and paragraphs;
- The active voice—showing who does what; and
- The most precise terms available, such as ''enrollee'' (rather than ''member'') for a beneficiary enrolled in an HMO or CMP; ''HCFA'' (rather than ''the Secretary'') since the responsibility for the prepaid health care programs has been delegated to HCFA; ''that'' (rather than ''which'') when the term limits or defines.

b. By eliminating unnecessary verbiage and outdated provisions.

II. Changes Made by This Rule

1. This rule amends § 417.1 to revise the definition of ''service area'' and to remove from the definition of ''health maintenance organizations'' the reference to §§ 417.168 and 417.169. Those sections were removed by a rule published on September 30, 1994 at 59 FR 49834.

2. The changes in subpart J are purely editorial, such as providing paragraph headings in § 417.410, and using present indicative to describe what HCFA does on a continuing basis.

3. In subpart K—

a. Special rules are highlighted by upgrading paragraphs to section status (new § 417.423).

b. Excessively long sentences are broken down to list and designate the separate provisions (paragraph (c) of § 417.440).

c. In § 417.460 (Disenrollment and termination of payments), we have reorganized the content to specify separately the circumstances under which disenrollment is required and those under which it is optional. We have also used more sections and eliminated unnecessary verbiage.

4. In subpart L, we have made technical and editorial changes, changes that, for example—

- Provide additional headings and more precise cross references; and
- Avoid unnecessary repetition.

5. In subpart M, we eliminated a ''definitions'' paragraph because, of the three terms defined, one was never used in the subpart, one was unnecessary, and the third was better explained in the only place it is used.

III. Waiver of Proposed Rulemaking and Delayed Effective Date

The changes made by this rule are technical and editorial in nature. Their aim is to simplify, clarify, and update subparts J, K, L, and M without substantive change. They have no impact on program costs. Accordingly, we find that notice and opportunity for public comment are unnecessary and contrary to the public interest and that, therefore, there is good cause to waive proposed rulemaking procedures.

In addition, it is important, for the convenience of the public, that these changes be effective as of October 1, l995, so that they will be included in the 1995 edition of Title 42 of the Code of Federal Regulations on which the public relies. Accordingly, we find good cause to waive the usual 30-day delay in the effective date.

As previously indicated, however, we will consider timely comments from anyone who believes that, in making the technical and editorial changes, we have unintentionally altered the substance. Although we cannot respond to comments individually, if we change these rules as a result of comments, we will discuss all timely comments in the preamble to the revised rules.

IV. Paperwork Reduction Act

These regulations contain no new information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980.

V. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA), and section 1102(b) of the Social Security Act (the Act), we prepare a regulatory flexibility analysis for each rule, unless we can certify that the rule will not have a significant economic impact on a substantial number of small entities, or a significant impact on the operation of a substantial number of small rural hospitals.

The RFA defines ''small entity'' as a small business, a nonprofit enterprise, or a governmental jurisdiction (such as a county, city, or township) with a population of less than 50,000. We also consider all providers and suppliers of services to be small entities. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that has fewer than 50 beds, and is not located in a metropolitan statistical area. We have not prepared a regulatory flexibility analysis because we have determined and we certify that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

We have not prepared a regulatory flexibility analysis because we have determined and certify that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this rule was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 417

Administrative practice and procedure, Health maintenance organizations (HMOs), Medicare.

42 CFR Part 417 is amended as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

A. The authority citation for Part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (U.S.C. 1302 and 1395hh); Secs. 1301, 1306 and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e-5, and 300e-9); and 31 U.S.C. 9701.

B. Subpart A is amended as follows:

Subpart A—General Provisions

1. In § 417.1, the following changes are made:

a. In the definition of ''health maintenance organization,'' the last comma and the words ''and §§ 417.168 and 417.169'' are removed.

b. The definition of ''service area'' is revised to read as set forth below.

§ 417.1 Definitions.

* * * * *

Service area means a geographic area, defined through zip codes, census tracts, or other geographic measurements, that is the area, as determined by HCFA, within which the HMO furnishes basic and supplemental health services and makes them available and accessible to all its enrollees in accordance with § 417.106(b).

* * * * *

§ 417.2 [Amended]

2. In paragraph (a) of § 417.2, ''Subparts A through F'' is revised to read ''Subparts B through F''.

C. Subpart J is amended as set forth below:

Subpart J—Qualifying Conditions for Medicare Contracts

1. Section 417.400 is revised to read as follows:

§ 417.400 Basis and scope.

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act, which authorizes Medicare payment to HMOs and CMPs that contract with HCFA to furnish covered services to Medicare beneficiaries.

(b) *Scope.* (1) This subpart sets forth the requirements an HMO or CMP must meet in order to enter into a contract with HCFA under section 1876 of the Act. It also specifies the procedures that HCFA follows to evaluate applications and make determinations.

(2) The rules for payment to HMOs and CMPs are set forth in subparts N, O, and P of this part.

(3) The rules for HCPP participation in Medicare under section 1833(a)(1)(A) of the Act are set forth in subpart U of this part.

2. § 417.401 is amended to add definitions of ''cost contract'', ''cost HMO or CMP'', and ''risk HMO or CMP'', in alphabetical order, and revise all other definitions except the definitions of ''adjusted average per capita cost'', ''demonstration project'', and ''geographic area'', to read as follows:

§ 417.401 Definitions.

* * * * *

Adjusted average per capita cost * * *

Adjusted community rate (ACR) is the equivalent of the premium that a risk HMO or CMP would charge Medicare enrollees independently of Medicare payments if the HMO or CMP used the same rates it charges non-Medicare enrollees for a benefit package limited to covered Medicare services.

Arrangement means a written agreement between an HMO or CMP and another entity, under which—

(1) The other entity agrees to furnish specified services to the HMO's or CMP's Medicare enrollees;

(2) The HMO or CMP retains responsibility for the services; and

(3) Medicare payment to the HMO or CMP discharges the beneficiary's obligation to pay for the services.

Benefit stabilization fund means a fund established by HCFA, at the request of a risk HMO or CMP, to withhold a portion of the per capita payments available to the HMO or CMP and pay that portion in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits the HMO or CMP provides to its Medicare enrollees.

Cost contract means a Medicare contract under which HCFA pays the HMO or CMP on a reasonable cost basis.

Cost HMO or CMP means an HMO or CMP that has in effect a cost contract with HCFA under section 1876 of the Act and subpart L of this part.

Demonstration project * * *

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions:

(1) Are needed immediately because of an injury or sudden illness.

(2) Are such that the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance and the nature of the medical condition.

Geographic area * * *

Medicare enrollee means a Medicare beneficiary who has been identified on HCFA records as an enrollee of an HMO or CMP that has a contract with HCFA under section 1876 of the Act and subpart L of this part.

New Medicare enrollee means a Medicare beneficiary who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part; and

(2) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

Risk contract means a Medicare contract under which HCFA pays the HMO or CMP on a risk basis for Medicare covered services.

Risk HMO or CMP means an HMO or CMP that has in effect a risk contract with HCFA under section 1876 of the Act and subpart L of this part.

Urgently needed services means covered services that are needed by an enrollee who is temporarily absent from the HMO's or CMP's geographic area and that—

(1) Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and

(2) Cannot be delayed until the enrollee returns to the HMO's or CMP's geographic area.

3. §§ 417.404, 417.406, and 417.407 are revised to read as follows:

§ 417.404 General requirements.

(a) In order to contract with HCFA under the Medicare program, an entity must—

(1) Be determined by HCFA to be an HMO or CMP (in accordance with §§ 117.142 and 417.407, respectively); and

(2) Comply with the contract requirements set forth in subpart L of this part.

(b) HCFA enters into or renews a contract only if it determines that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

§ 417.406 Application and determination.

(a) *Responsibility for making determinations.* HCFA is responsible for determining whether an entity meets the requirements to be an HMO or CMP.

(b) *Application requirements.* (1) The application requirements for HMOs are set forth in § 417.143.

(2) The requirements of § 417.143 also apply to CMPs except that there are no application fees.

(c) *Determination.* HCFA uses the procedures set forth in § 417.144(a) through (d) to determine whether an entity is an HMO or CMP.

(d) *Oversight of continuing compliance.* (1) HCFA oversees an entity's continued compliance with the requirements for an HMO as defined in § 417.1 or for a CMP as set forth in § 417.407.

(2) If an entity no longer meets those requirements, HCFA terminates the contract of that entity in accordance with § 417.494.

§ 417.407 Requirements for a Competitive Medical Plan (CMP).

(a) *General rule.* To qualify as a CMP, an entity must be organized under the

laws of a State and must meet the requirements of paragraphs (b) through (f) of this section.

(b) *Required services*—(1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, the entity furnishes to its enrollees at least the following services:

(i) Physicians' services performed by physicians.

(ii) Laboratory, x-ray, emergency, and preventive services.

(iii) Out-of-area coverage.

(iv) Inpatient hospital services.

(2) Exception for Medicaid prepayment risk contracts. An entity that had, before 1970, a Medicaid prepayment risk contract that did not include provision of inpatient hospital services is not required to provide those services.

(c) *Compensation for services.* The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee.

(d) *Source of physicians' services.* The entity provides physicians' services primarily through—

(1) Physicians who are employees or partners of the entity; or

(2) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(e) *Assumption of financial risk.* The rules set forth in § 417.120(b) for HMOs apply also to CMPs except that reference to ''basic services'' must be read as reference to the required services listed in paragraph (b) of this section.

(f) *Protection of enrollees.* The entity provides adequately against the risk of insolvency by meeting the requirements of §§ 417.120(a) and 417.122 for protection of enrollees against loss of benefits and liability for payment of any fees that are the legal responsibility of the entity.

§ 417.408 [Amended]

4. In § 417.408, the following changes are made:

a. In paragraph (a), the designation ''(1)'' is inserted before the first sentence, the designation ''(2)'' is inserted before the second sentence, and ''will exempt'' is revised to read ''exempts''.

b. In paragraphs (b)(1) and (c) introductory text, ''will give'' is revised to read ''gives''.

5. Section 417.410 is amended to revise the section heading and provide headings for paragraphs (a) through (f), to read as follows:

§ 417.410 Qualifying conditions: General rules.

(a) *Basic requirement.* * * *

(b) *Other qualifying conditions.* * * *

(c) *Standards.* * * *

(d) *Application of standards.* * * *

(e) *Requirements for a risk contract.* * * *

(f) *Requirements for a reasonable cost contract.* * * *

* * * * *

§ 417.412 [Amended]

6. In § 417.412, the following changes are made:

a. Paragraph (a) and the designation ''(b)'' are removed.

b. Paragraphs (b)(1) and (b)(2) are redesignated as paragraphs (a) and (b), respectively.

7. In § 417.413, paragraphs (b) introductory text, (b)(1), (b)(2), (c), (d)(2)(i), (d)(3), (d)(5), and (d)(6) are revised to read as follows:

§ 417.413 Qualifying condition: Operating experience and enrollment.

* * * * *

(b) *Standard: Enrollment and operating experience for HMOs or CMPs to contract on a risk basis.* To be eligible to contract on a risk basis—

(1) A nonrural HMO or CMP must currently have the following:

(i) At least 5,000 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within 2 years from the beginning of its initial contract period.

(2) A rural HMO or CMP must currently have—

(i) At least 1,500 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within 2 years from the beginning of its initial contract period.

* * * * *

(c) *Standard: Enrollment and operating experience for HMOs or CMPs to contract on a cost basis.* To be eligible to contract on a reasonable cost basis, an HMO or CMP must currently have enrollees sufficient in number to provide a reasonable basis for entering into a contract, as follows:

(1) At least 1,500 enrollees.

(2) At least 75 Medicare enrollees, or a plan acceptable to HCFA for achieving—

(i) A Medicare enrollment of 75 within 2 years from the beginning of its initial contract period; and

(ii) At least 250 Medicare enrollees by the beginning of its fourth contract period.

(d) *Standard: Composition of enrollment.*

(1) * * *

(2) *Waiver of composition of enrollment standard.* * * *

(i) The HMO or CMP serves a geographic area in which Medicare beneficiaries and Medicaid recipients constitute more than 50 percent of the population. (HCFA does not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees to exceed the percentage of Medicare beneficiaries and Medicaid recipients in the population of the geographic area.)

* * * * *

(3) *Waiver granted on or before October 21, 1986.* An HMO or CMP (or a successor HMO or CMP) that as of October 21, 1986, had been granted an exception, waiver, or modification of the requirements of paragraph (d)(1) of this section, but that does not meet the requirements of paragraph (d)(2) of this section, must make (and throughout the period of the exception, waiver, or modification continue to make) reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by HCFA.

(i) If HCFA determines that the HMO or CMP has complied, or made significant progress toward compliance, with the approved schedule, and that an extension is in the best interest of the Medicare program, HCFA may extend the waiver of modification.

(ii) If HCFA determines that the HMO or CMP has not complied with the approved schedule, HCFA may apply the sanctions described in paragraphs (d)(6) and (d)(7) of this section.

* * * * *

(5) *Notice of sanction.* Before applying the sanctions specified in paragraph (d)(6) of this section, HCFA sends a written notice to the HMO or CMP stating the proposed action and its basis. HCFA gives the HMO or CMP 15 days after the date of the notice to provide evidence establishing the HMO's or CMP's compliance with the requirements in paragraph (d)(1), (d)(2), or (d)(3) of this section, as applicable.

(6) *Sanctions.* If, following review of the HMO's or CMP's timely response to HCFA's notice, HCFA determines that an HMO or CMP does not comply with the requirements of paragraphs (d)(1), (d)(2), or (d)(3) of this section, HCFA may apply either of the following sanctions:

(i) Require the HMO or CMP to stop accepting new enrollment applications after a date specified by HCFA.

(ii) Deny payment for individuals who are formally added or ''accreted'' to

HCFA's records as Medicare enrollees after a date specified by HCFA.

* * * * *

§ 417.414 [Amended]

8. In § 417.414, the following changes are made:

a. In paragraph (b)(1), the word ''that'' is revised to read ''to the extent that they''.

b. Paragraph (b)(4) is removed.

9. Section 417.416 is amended by revising paragraphs (b) and (d), to read as follows:

§ 417.416 Qualifying condition: Furnishing of services.

* * * * *

(b) *Standard: Conformance with conditions of participation, conditions for coverage, and conditions for certification.* (1) Hospitals, SNFs, HHAs, CORFs, and providers of outpatient physical therapy or speech-language pathology services must meet the applicable conditions of participation in Medicare, as set forth elsewhere in this chapter.

(2) Suppliers must meet the conditions for coverage or conditions for certification of their services, as set forth elsewhere in this chapter.

(3) If more than one type of practitioner is qualified to furnish a particular service, the HMO or CMP may select the type of practitioner to be used.

* * * * *

(d) *Exceptions to physician supervision requirement.* The following services may be furnished without the direct personal supervision of a physician:

(1) Services of physician assistants and nurse practitioners (as defined in § 491.2 of this chapter), and the services and supplies incident to their services. The conditions for payment, as set forth in §§ 405.2414 and 405.2415 of this chapter for services furnished by rural health clinics and Federally qualified health centers, respectively, also apply when those services are furnished by an HMO or CMP.

(2) When furnished by a risk HMO or CMP, services of clinical psychologists, and services and supplies incident to their professional services. For purposes of this section, a clinical psychologist is an individual who—

(i) Holds a doctoral degree in psychology from an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation;

(ii) Is licensed or certified at the independent practice level of psychology in the State in which he or she practices; and

(iii) Has 2 years of supervised clinical experience at least l of which is postgraduate.

* * * * *

D. Subpart K is amended as set forth below:

§ 417.420 [Amended]

1. In § 417.420, the following changes are made:

a. In paragraph (b), ''Medicare will make payments to the HMO or CMP'' is revised to read ''HCFA pays the HMO or CMP''.

b. In paragraph (b), the phrase '', as described in § 417.440,'' is removed.

c. In paragraph (c)(1), the phrase ''as authorized in § 417.440'' is removed.

§ 417.422 [Amended]

2. In § 417.422, the following changes are made:

a. In paragraph (a), the designation ''(a)'' and the heading are removed and ''§ 417.424 and paragraphs (b) and (c) of this section'' is revised to read ''§§ 417.423 and 417.424''.

b. The designation of paragraphs (a)(1) through (a)(7), is changed to ''(a)'' through ''(g)'', respectively.

c. Paragraphs (b) and (c) are removed.

3. A new § 417.423 is added, to read as follows:

§ 417.423 Special rules: ESRD and hospice patients.

(a) *ESRD patients.* (1) A Medicare beneficiary who has been medically determined to have end-stage renal disease is not eligible to enroll in an HMO or CMP.

(2) However, if a beneficiary is already enrolled in an HMO or CMP when he or she is determined to have end-stage renal disease, the HMO or CMP—

(i) Must reenroll the beneficiary as required by § 417.434; and

(ii) May not disenroll the beneficiary except as provided in § 417.460.

(b) *Hospice patients.* A Medicare beneficiary who elects hospice care under § 418.24 of this chapter is not eligible to enroll in an HMO or CMP as long as the hospice election remains in effect.

§ 417.424 [Amended]

4. In § 417.424, the following changes are made:

a. In paragraph (b), the designation ''(1)'' is inserted before the first sentence and the designation ''(2)'' is inserted before the second sentence.

b. In newly designated paragraph (b)(2), the phrase ''(as defined in § 417.413(f)(2))'' is removed, and the phrase ''its proportion to the general population'' is revised to read ''the subgroup's proportion of the general population''.

c. The following parenthetical statement is added at the end of newly designated paragraph (b)(2): ''(A subgroup is a class of Medicare enrollees of an HMO or CMP that HCFA constructs on the basis of actuarial factors.)''.

5. In § 417.426, paragraphs (b)(2) and (c) are revised to read as follows:

§ 417.426 Open enrollment requirements.

* * * * *

(b) *Capacity to accept new enrollees.*

* * *

(2) HCFA evaluates the HMO's or CMP's submittal under paragraph (b)(1) of this section.

* * * * *

(c) *Reserved vacancies.* (1) Subject to HCFA's approval, an HMO or CMP may set aside a reasonable number of vacancies for an anticipated new group contract or for anticipated new enrollees under an existing group contract that will have its enrollment period after the Medicare open enrollment period during the contract year.

(2) Any set aside vacancies that are not filled within a reasonable time after the beginning of the group contract enrollment period must be made available to Medicare beneficiaries and other nongroup applicants under the requirements of this subpart.

§ 417.428 [Amended]

6. In § 417.428, paragraph (c), ''risk reimbursement'' is revised to read ''payment on a risk basis''.

7. In § 417.430, the following changes are made:

a. Paragraph (b)(3) is revised to read as set forth below.

b. In paragraph (b)(6)(i), ''accepted while the organization was enrolled to capacity'' is revised to read ''accepted (for future enrollment) while there were no vacancies.''

§ 417.430 Application procedures.

* * * * *

(b) *Handling of applications.* * * *

(3) The HMO or CMP gives the beneficiary prompt written notice of acceptance or rejection of the application.

* * * * *

§ 417.432 [Corrected]

8. In § 417.432, the heading of paragraph (e) is corrected to read: ''(e) *Expedited submittal of information to HCFA.*''

9. Section 417.440 is amended to revise paragraphs (b)(1), (c), and (d) introductory text, to read as follows:

§ 417.440 Entitlement to health care services from an HMO or CMP.

* * * * *

(b) *Scope of services*—(1) *Part A and Part B services.* Except as specified in paragraphs (c), (d), and (e) of this section, a Medicare enrollee is entitled to receive from an HMO or CMP all the Medicare-covered services that are available to individuals residing in the HMO's or CMP's geographic area, as follows:

(i) Medicare Part A and Part B services if the enrollee is entitled to benefits under both programs.

(ii) Medicare Part B services if the enrollee is entitled only under that program.

* * * * *

(c) *Limitation on hospice care*—(1) *Extent of limitation*—(i) *Basic rule.* Except as provided in paragraph (c)(1)(ii) of this section, a Medicare enrollee who elects to receive hospice care under § 418.24 of this chapter waives the right to receive from the HMO or CMP any Medicare services (including services equivalent to hospice care) that are related to the terminal condition for which the enrollee elected hospice care, or to a related condition.

(ii) *Exception.* An enrollee who elects hospice care retains the right to services furnished by his or her attending physician if that physician—

(A) Is an employee or contractor of the HMO or CMP; and

(B) Is not an employee of the designated hospice and does not receive compensation from the hospice for those services.

(2) *Effective date of limitation.* The limitation in paragraph (c)(1) of this section begins on the effective date of the beneficiary's election of hospice care and remains in effect until the earlier of the following:

(i) The effective date of the enrollee's revocation of the election of hospice care as described in § 418.28 of this chapter.

(ii) The date the enrollee exhausts his or her hospice benefits.

(3) *Payment to HMO or CMP.* For the period that the Medicare enrollee's election of hospice care is in effect, HCFA pays a cost HMO or CMP only as described in § 417.585.

(d) *Limitation on provision of inpatient hospital services.* If a beneficiary's effective date of coverage, as specified in § 417.450, in a risk HMO or CMP occurs during an inpatient stay in a hospital paid for under part 412 of this chapter, the HMO or CMP—

* * * * *

10. In § 417.442, the heading and paragraph (a) are revised to read as follows:

§ 417.442 Risk HMOs and CMPs: Conditions for provision of additional benefits.

(a) *General rule.* Except as provided in paragraph (b) of this section, a risk HMO or CMP must, during any contract period, provide to its Medicare enrollees the additional benefits described in § 417.440(b)(4) if its ACRs (calculated in accordance with § 417.594) are less than the average per capita rates that HCFA pays for the Medicare enrollees during the contract period.

11. In § 417.450, paragraph (c) is revised to read as follows:

§ 417.450 Effective date of coverage.

* * * * *

(c) *Notice of effective date of coverage.* For each beneficiary added to HCFA's records as an enrollee of an HMO or CMP, HCFA gives the HMO or CMP prompt written notice of the month with which HCFA's liability begins.

§ 417.452 [Amended]

12. In § 417.452, the following changes are made:

a. In paragraph (a)(1), ''under § 417.442'' is revised to read ''under the additional benefits provision of § 417.442''.

b. In paragraph (a)(2) ''may be paid by the enrollee or on his or her behalf by another individual, organization or entity.'' is revised to read ''may be paid by or on behalf of the enrollee in the form of a premium, membership fee, charge per unit, or other similar charge.'', and the second sentence is removed.

c. In paragraph (b) introductory text, ''provided under § 417.442'' is revised to read ''provided as additional benefits under § 417.442''.

§ 417.454 [Amended]

13. In § 417.454, the heading of paragraph (a) is revised to read *''Limits on charges.''*

§ 417.456 [Amended]

14. In § 417.456, in paragraph (f), ''will reduce'' is revised to read ''reduces'', and ''arrange'' is revised to read ''arranges''.

§ 417.458 [Amended]

15. In § 417.458, introductory text, ''agrees to recoup'' is revised to read ''agrees not to recoup'', and ''only in the following circumstances'' is revised to read ''except in the following circumstances''.

16. Section 417.460 is revised and new sections 417.461 and 417.464 are added, to read as follows:

§ 417.460 Disenrollment of beneficiaries by an HMO or CMP.

(a) *General rule.* Except as provided in paragraphs (b) through (i) of this section, an HMO or CMP may not—

(1) Disenroll a Medicare beneficiary; or

(2) Orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll.

(b) *Bases for disenrollment: Overview*—(1) *Optional disenrollment.* Generally, an HMO or CMP may disenroll a Medicare enrollee if he or she—

(i) Fails to pay the required premiums or other charges;

(ii) Commits fraud or permits abuse of his or her enrollment card; or

(iii) Behaves in a manner that seriously impairs the HMO's or CMP's ability to furnish health care services to the particular enrollee or to other enrollees.

(2) *Required disenrollment.* Generally, an HMO or CMP must disenroll a Medicare enrollee if he or she—

(i) Moves out of the HMO's or CMP's geographic area;

(ii) Fails to convert to the risk provisions of the HMO's or CMP's Medicare contract;

(iii) Loses entitlement to Medicare Part B benefits; or

(iv) Dies.

(3) *Related provisions.* Specific requirements, limitations, and exceptions are set forth in paragraphs (c) through (i) of this section.

(c) *Failure to pay premiums or other charges—(1) Basic rule.* Except as specified in paragraph (c)(2) of this section, an HMO or CMP may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the HMO or CMP for deductible and coinsurance amounts for which the enrollee is liable, if the HMO or CMP—

(i) Can demonstrate to HCFA that it made reasonable efforts to collect the unpaid amount;

(ii) Gives the enrollee written notice of disenrollment, including an explanation of the enrollee's right to a hearing under the HMO's or CMP's grievance procedures; and

(iii) Sends the notice of disenrollment to the enrollee before it notifies HCFA.

(2) *Exception.* If the enrollee fails to pay the premium for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept), but pays the basic premium and other charges, the HMO or CMP may discontinue the optional

benefits but may not disenroll the beneficiary.

(d) *Enrollee commits fraud or permits abuse of the enrollment card*—(1) *Basis for disenrollment.* An HMO or CMP may disenroll a Medicare beneficiary if the beneficiary—

(i) Knowingly provides, on the application form, fraudulent information that materially affects the beneficiary's eligibility to enroll in the HMO or CMP; or

(ii) Intentionally permits others to use his or her enrollment card to obtain services from the HMO or CMP.

(2) *Notice requirement.* If disenrollment is for either of the reasons specified in paragraph (d)(1) of this section, the HMO or CMP must give the beneficiary a written notice of termination of enrollment.

(i) The notice must be mailed to the enrollee before submission of the disenrollment notice to HCFA.

(ii) The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established in accordance with § 417.436.

(3) *Report to the Inspector General.* The HMO or CMP must report to the Office of the Inspector General of the Department any disenrollment based on fraud or abuse by the enrollee.

(e) *Disenrollment for cause*—(1) *Basis for disenrollment.* An HMO or CMP may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing enrollment in the HMO or CMP seriously impairs the HMO's or CMP's ability to furnish services to either the particular enrollee or other enrollees.

(2) *Effort to resolve the problem.* The HMO or CMP must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(3) *Consideration of extenuating circumstances.* The HMO or CMP must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness.

(4) *Documentation.* The HMO or CMP must document the problems, efforts, and medical conditions as described in paragraphs (e)(1) through (e)(3) of this section.

(5) *HCFA review of an HMO's or CMP's proposed disenrollment for cause.* (i) HCFA decides on the basis of review of the documentation submitted by the HMO or CMP, whether disenrollment requirements have been met.

(ii) HCFA makes this decision within 20 working days after receipt of the documentation material, and notifies the HMO or CMP within 5 working days after making its decision.

(6) *Effective date of disenrollment.* If HCFA permits an HMO or CMP to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the HMO or CMP gives the enrollee a written notice of disenrollment that meets the requirements set forth in paragraphs (d)(2)(i) and (d)(2)(ii) of this section.

(f) *Enrollee moves out of the HMO's or CMP's geographic area*—(1) *Basic rules*—(i) *Disenrollment.* Except as provided in paragraph (f)(2) of this section, an HMO or CMP must disenroll a Medicare enrollee who moves out of its geographic area if the HMO or CMP establishes, on the basis of a written statement from the enrollee, or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area.

(ii) *Notice requirement.* The HMO or CMP must comply with the notice requirements set forth in paragraph (d)(2) of this section.

(iii) *Effect on geographic area.* Failure to disenroll an enrollee who has moved out of the HMO's or CMP's geographic area does not expand that area to encompass the location of the enrollee's new residence.

(2) *Exception.* An HMO or CMP may retain a Medicare enrollee who is absent from its geographic area for an extended period, but who remains within the United States as defined in § 400.200 of this chapter if the enrollee agrees. For purposes of this exception, the following provisions apply:

(i) An absence for an extended period means an uninterrupted absence from the HMO's or CMP's geographic area for more than 90 days but less than 1 year.

(ii) The HMO or CMP and the enrollee may mutually agree upon restrictions for obtaining services while the enrollee is absent for an extended period from the HMO's or CMP's geographic area. However, restrictions may not be imposed on the scope of services described in § 417.440.

(iii) HMOs and CMPs that choose to exercise this exception must make the option available to all Medicare enrollees who are absent for an extended period from their geographic areas. However, HMOs and CMPs may limit this option to enrollees who go to a geographic area served by an affiliated HMO or CMP.

(iv) As used in this paragraph, ''affiliated HMO or CMP'' means an HMO or CMP that—

(A) Is under common ownership or control of the HMO or CMP that seeks to retain the absent enrollees; or

(B) Has in effect an agreement to furnish services to enrollees who are on an extended absence from the geographic area of the HMO or CMP that seeks to retain them.

(v) When the enrollee returns to the HMO's or CMP's geographic area (even temporarily), the restrictions of § 417.448(a) (which limit payment for services not provided or arranged for by the HMO or CMP) apply again immediately.

(vi) If the enrollee fails to return to the HMO's or CMP's geographic area within 1 year from the date he or she left that area, the HMO or CMP must disenroll the beneficiary on the first day of the month following the anniversary of the date the enrollee left that area in accordance with paragraph (f)(1) of this section.

(g) *Failure to convert to risk provisions of Medicare contract*—(1) *Basis for disenrollment.* A risk HMO or CMP must disenroll a nonrisk Medicare enrollee who refuses to convert to the risk provisions of the Medicare contract after HCFA determines that all of the HMO's or CMP's nonrisk Medicare enrollees must convert.

(2) *Advance notice requirement.* At least 30 days before it gives HCFA notice of disenrollment, the HMO or CMP must give the enrollee written notice of the fact that failure to convert will result in disenrollment.

(h) *Loss of entitlement to Medicare benefits*—(1) *Loss of entitlement to Part A benefits.* If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the HMO or CMP and is entitled to receive and have payment made for Part B services, beginning with the month immediately following the last month of his or her entitlement to Part A benefits.

(2) *Loss of entitlement to Part B benefits.* If a Medicare enrollee loses entitlement to Part B benefits, the HMO or CMP must disenroll him or her as a Medicare enrollee effective with the month following the last month of entitlement to Part B benefits. However, the HMO or CMP may continue to enroll the individual under its regular plan if the individual so chooses.

(i) *Death of the enrollee.* Disenrollment is effective with the month following the month of death.

§ 417.461 Disenrollment by the enrollee.

(a) *Request for disenrollment.* (1) A Medicare enrollee who wishes to

disenroll may at any time give the HMO or CMP a signed, dated request in the form and manner prescribed by HCFA.

(2) The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the HMO or CMP receives the request.

(b) *Responsibilities of the HMO or CMP.* The HMO or CMP must—

(1) Submit a disenrollment notice to HCFA promptly;

(2) Provide the enrollee with a copy of the request for disenrollment; and

(3) In the case of a risk HMO or CMP, also provide the enrollee with a statement explaining that he or she—

(i) Remains enrolled until the effective date of disenrollment; and

(ii) Until that date, is subject to the restrictions of § 417.448(a) under which neither the HMO or CMP nor HCFA pays for services not provided or arranged for by the HMO or CMP.

(c) *Effect of failure to submit disenrollment notice to HCFA promptly.* If the HMO or CMP fails to submit timely the correct and complete notice required in paragraph (b)(1) of this section, the HMO or CMP must reimburse HCFA for any capitation payments received after the month in which payments would have ceased if the requirement had been met timely.

§ 417.464 End of HCFA's liability for payment: Disenrollment of beneficiaries and termination or default of contract.

(a) *Effect of disenrollment: General rule.* (1) HCFA's liability for monthly capitation payments to the HMO or CMP generally ends as of the first day of the month following the month in which disenrollment is effective, as shown on HCFA's records.

(2) Disenrollment is effective no earlier than the month immediately after, and no later than the third month after, the month in which HCFA receives the disenrollment notice in acceptable form.

(b) *Effect of disenrollment: Special rules*—(1) *Fraud or abuse by the enrollee.* If disenrollment is on the basis of fraud committed or abuse permitted by the enrollee, HCFA's liability ends as of the first day of the month in which disenrollment is effective.

(2) *Loss of entitlement to Part B benefits.* If disenrollment is on the basis of loss of entitlement to Part B benefits, HCFA's liability ends as of the first day of the month following the last month of Part B entitlement.

(3) *Death of enrollee.* If the enrollee dies, HCFA's liability ends as of the first day of the month following the month of death.

(4) *Disenrollment at enrollee's request.* If disenrollment is in response to the enrollee's request, HCFA's liability ends as of the first day of the month following the month of termination requested by the enrollee.

(c) *Effect of termination or default of contract*—(1) *Termination of contract.* If the contract between HCFA and the HMO or CMP is terminated by mutual consent or by unilateral action of either party, HCFA's liability for payments ends as of the first day of the month after the last month for which the contract is in effect.

(2) *Default of contract.* If the HMO or CMP defaults on the contract before the end of the contract year because of bankruptcy or other reasons, HCFA—

(i) Determines the month in which its liability for payments ends; and

(ii) Notifies the HMO or CMP and all affected Medicare enrollees as soon as practicable.

E. Subpart L is amended as set forth below:

Subpart L—Requirements for Medicare Contracts

1. Section 417.472 is amended to revise paragraphs (a) and (b) to read as follows:

§ 417.472 Basic contract requirements.

(a) *Submittal of contract.* An HMO or CMP that wishes to contract with HCFA to furnish services to Medicare beneficiaries must submit a signed contract that meets the requirements of this subpart and any other requirements established by HCFA.

(b) *Agreement to comply with regulations and instructions.* The contract must provide that the HMO or CMP agrees to comply with all the applicable requirements and conditions set forth in this subpart and in general instructions issued by HCFA.

* * * * *

2. Sections 417.474 and 417.476 are revised to read as follows:

§ 417.474 Effective date and term of contract.

(a) *Effective date.* The contract must specify its effective date, which may not be earlier than the date it is signed by both HCFA and the HMO or CMP.

(b) *Term.* The contract must specify the duration of its term as follows:

(1) For the initial term, at least 12 months, but no more than 23 months.

(2) For any subsequent term, 12 months.

§ 417.476 Waived conditions.

If HCFA waives any of the qualifying conditions required under subpart J of this part, the contract must specify the following information for each waived condition:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by HCFA.

3. Section 417.480 is amended to revise the heading and the introductory text to read as follows:

§ 417.480 Maintenance of records: Cost HMOs and CMPs.

A reasonable cost contract must provide that the HMO or CMP agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that—

* * * * *

4. In § 417.481, the heading and the introductory text are revised to read as follows:

§ 417.481 Maintenance of records: Risk HMOs and CMPs.

A risk contract must provide that the HMO or CMP agrees to maintain and make available to HCFA upon request, books, records, documents, and other evidence of accounting procedures and practices that—

* * * * *

5. In § 417.486, the following changes are made:

a. In the introductory text, the word ''agrees'' is revised to read ''agrees to the following:''.

b. In paragraph (a)(1), ''§§ 417.530 through 417.576'' is revised to read ''subpart O of this part''.

c. At the end of paragraphs (b) and (c), periods are substituted for the '';'' and ''; and '', respectively.

d. Paragraph (d) is revised to read as follows:

§ 417.486 Disclosure of information and confidentiality.

* * * * *

(d) To meet the confidentiality requirements of § 482.24(b)(3) of this chapter for medical records and for all other enrollee information that is—

(1) Contained in its records or obtained from HCFA or other sources; and

(2) Not covered under paragraph (c) of this section.

6. Section 417.488 is revised to read as follows.

§ 417.488 Notice of termination and of available alternatives: Risk contract.

A risk contract must provide that the HMO or CMP agrees to give notice as follows if the contract is terminated:

(a) At least 60 days before the effective date of termination, to give its Medicare enrollees a written notice that—

(1) Specifies the termination date; and

(2) Describes the alternatives available for obtaining Medicare services after termination.

(b) To pay the cost of the written notices.

7. In § 417.492, the introductory text of paragraph (a)(1) is republished and paragraphs (a)(l)(iii) and (b) are revised to read as follows:

§ 417.492 Nonrenewal of contract.

(a) *Nonrenewal by the HMO or CMP.* (1) If an HMO or CMP does not intend to renew its contract, it must—

* * * * *

(iii) Notify the general public at least 30 days before the end of the contract period, by publishing a notice in one or more newspapers of general circulation in each community or county located in the HMO's or CMP's geographic area.

* * * * *

(b) *Nonrenewal by HCFA*—(1) *Notice of nonrenewal.* If HCFA decides not to renew a contract, it gives written notice of nonrenewal as follows:

(i) To the HMO or CMP at least 90 days before the end of the contract period.

(ii) To the HMO's or CMP's Medicare enrollees at least 60 days before the end of the contract period.

(iii) To the general public at least 30 days before the end of the contract period.

(2) *Notice of appeal rights.* HCFA gives the HMO or CMP written notice of its right to appeal the nonrenewal decision, in accordance with subpart R of this part, if HCFA's decision was based on any of the reasons specified in § 417.494(b).

8. Section 417.494 is amended to revise paragraphs (a)(3), (b)(1)(iv), (b)(2), (b)(4), (c)(4), and (c)(5), to read as follows:

§ 417.494 Modification or termination of contract.

(a) *Modification or termination by mutual consent.* * * *

(3) If the contract is terminated, the HMO or CMP must notify its Medicare enrollees, and HCFA notifies the general public, at least 30 days before the termination date.

(b) *Termination by HCFA.* (1) * * *

(iv) HCFA determines that the HMO or CMP no longer meets the requirements of section 1876 of the Act and this subpart for being an HMO or CMP.

(2) If HCFA decides to terminate a contract, it sends a written notice informing the HMO or CMP of its right to appeal the termination in accordance with subpart R of this part.

(3) * * *

(4) HCFA notifies the HMO's or CMP's Medicare enrollees and the general public of the termination at least 30 days before the effective date of termination.

(c) *Termination by the HMO or CMP.* * * *

(4) The contract is terminated effective 60 days after the HMO or CMP mails the notice to Medicare enrollees as required in paragraph (c)(2) of this section.

(5) HCFA's liability for payment ends as of the first day of the month after the last month for which the contract is in effect.

§ 417.500 [Amended]

9. In § 417.500, the following changes are made:

a. In paragraph (a) introductory text, ''termination'' is revised to read ''termination of contract'', and ''with a contract under this subpart'' is removed.

b. In paragraphs (a)(3) and (a)(4), ''this part'' is revised to read ''subpart K of this part''.

c. The heading of paragraph (b) is revised to read ''*Notice of sanction and opportunity to respond.*''

d. The heading ''*Notice of sanction.*'' is added to paragraph (b)(1).

e. The heading ''*Opportunity to respond.*'' is added to paragraph (b)(2).

F. Subpart M is amended as set forth below:

Subpart M—Change of Ownership and Leasing of Facilities: Effect on Medicare Contracts

1. Section 417.520 is revised to read as follows:

§ 417.520 General provisions.

(a) *What constitutes change of ownership*—(1) *Partnership.* The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law, constitutes a change of ownership.

(2) *Unincorporated sole proprietor.* Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation.* (i) The merger of the HMO's or CMP's corporation into another corporation or the consolidation of the HMO or CMP with one or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation into the HMO's or CMP's corporation, with the HMO or CMP surviving, does not ordinarily constitute change of ownership.

(b) *Advance notice requirement.* (1) An HMO or CMP that has a Medicare contract in effect and is considering or negotiating a change in ownership must notify HCFA at least 60 days before the anticipated effective date of the change.

(2) If the HMO or CMP fails to give HCFA the required notice timely, it continues to be liable for capitation payments that HCFA makes to it on behalf of Medicare enrollees after the date of change of ownership.

(c) *Novation agreement defined.* A novation agreement is an agreement among the current owner of the HMO or CMP, the prospective new owner, and HCFA—

(1) That is embodied in a document executed and signed by all three parties;

(2) That meets the requirements of § 417.522; and

(3) Under which HCFA recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(d) *Effect of change of ownership without novation agreement.* Except to the extent provided in paragraph (b)(2) of this section, the effect of a change of ownership without a novation agreement is that—

(1) The existing contract becomes invalid; and

(2) If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart L of this part.

(e) *Effect of change of ownership with novation agreement.* If the HMO or CMP submits a novation agreement that meets the requirements of § 417.522, and HCFA signs it, the new owner becomes the successor in interest to the current owner's Medicare contract.

§ 417.521 [Removed]

2. Section 417.521 is removed.

§ 417.522 [Amended]

3. In § 417.522, the following changes are made:

a. In paragraph (a) introductory text, ''will approve'' is revised to read ''approves''.

b. In paragraph (a)(3)(iii), ''under this part'' is revised to read ''under subpart J of this part''.

§ 417.523 [Amended]

4. In § 417.523, the following changes are made:

a. In paragraph (a), the heading is revised to read ''*General effect of leasing.*''.

b. In the text of paragraph (a) and in paragraph (b)(2), ''the lessee'' is revised to read ''the other entity''.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 22, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–21626 Filed 8–31–95; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 649

[Docket No. 950824215–5217–02; I.D. 080195B]

American Lobster Fishery; Technical Amendment; Clarifies Eligibility Requirements

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule; technical amendment.

SUMMARY: NMFS issues this final rule to amend the regulations governing the Fishery Management Plan for the American Lobster Fishery (FMP). This rule corrects the eligibility requirements for lobster limited access permits to allow permit applicants who own a vessel that was under written contract for purchase as of March 25, 1991, to qualify for the limited access permit.

EFFECTIVE DATE: August 31, 1995.

FOR FURTHER INFORMATION CONTACT: Paul H. Jones, Fishery Policy Analyst, 508–281–9273.

SUPPLEMENTARY INFORMATION: Currently, regulations provide that eligibility for a lobster limited access permit can be established by proof that the permit applicant owned a vessel that was under written agreement for construction or for rerigging for directed American lobster fishing as of March 25, 1991 (60 FR 21994, May 4, 1995). This action makes a correction to these eligibility requirements by allowing vessels owners who entered into a written contract to purchase a vessel for directed American lobster fishing as of March 25, 1991, to qualify for a lobster limited access permit. The New England Fishery Management Council clarified at its June 29, 1995, meeting that this provision of the eligibility requirements for a limited access permit was inadvertently omitted from the regulations implementing Amendment 5 to the Lobster FMP.

Classification

Because this rule only corrects an omission in an existing set of regulations for which full prior notice and opportunity for comment have been given, under 5 U.S.C. 553(b)(B) it is unnecessary to provide additional notice and opportunity for comment.

This action imposes no new requirements on anyone subject to these regulations, but instead relieves a restriction. Accordingly, under 5 U.S.C. 553(d), this action may be made immediately effective.

This rule is exempt from review under E.O. 12866.

List of Subjects in 50 CFR Part 649

Fisheries.

Dated: August 25, 1995.

Gary Matlock,

Program Management Officer, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 649 is amended as follows:

PART 649—AMERICAN LOBSTER FISHERY

1. The authority citation for part 649 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 649.4, the first sentence of paragraph (b)(1)(i)(C) is revised to read as follows:

§ 649.4 Vessel permits.

(b) * * *

(1) * * *

(i) * * *

(C) The vessel was under written agreement for construction or rerigging for directed American lobster fishing, or was under written contract for purchase as of March 25, 1991, and the applicant meets one of the eligibility criteria set forth in paragraph (b)(1)(i)(A) or (B) of this section. * * *

* * * * *

[FR Doc. 95–21779 Filed 8–31–95; 8:45 am]

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